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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1615)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): We'll call our meeting to order.

We apologize for the confusion and delay. We'll do the best we can to make sure we get your points of view on this, but again, I apologize.

We have on the agenda committee business. We're not going to do the committee business but go right to the witnesses.

Welcome to meeting number 107 of the Standing Committee on Health. We are studying diabetes strategies in Canada and abroad.

We have five organizations represented today, all to make presentations. Each organization has a five-minute opening statement.

From Diabetes Canada, we have Dr. Jan Hux, president, and Kimberley Hanson, director of federal affairs.

From Juvenile Diabetes Research Foundation Canada, we have Dave Prowten, CEO and president, and Patrick Tohill, director of government relations.

From the Ordre des infirmières et infirmiers du Québec, we have Lucie Tremblay, president, and Joël Brodeur, director of professional development and support.

From Diabetes Action Canada, we have Dr. Catharine Whiteside, executive director.

From Canadian Indigenous Nurses Association we have Marilee Nowgesic, executive director, and Isabelle Wallace, indigenous nursing adviser.

We welcome all of you. We really appreciate your taking the time to come and help us with this study.

We'll start with Diabetes Canada for a five-minute opening statement and we will see how it goes.

Dr. Jan Hux (President, Diabetes Canada): Good afternoon. I'd like to thank the committee for the opportunity to appear today and for its commitment to study the important issue of diabetes. Thanks in particular to the all-party diabetes caucus and chair Sonia Sidhu for their dedication to this cause.

In Canada today, one in three people lives with diabetes or pre-diabetes. In some communities, that rate soars to 60%. Canadians in their twenties now face a 50% chance of developing diabetes in their lifetime, and in first nations communities the risk is 80%. More than twice as many Canadians live with diabetes today as in the year 2000.

Diabetes is an epidemic, an epidemic that fuels health inequities, particularly touching seniors and those of South Asian, Asian, and African ethnic backgrounds. Those inequities are even more striking in indigenous communities, which face both much higher rates of diabetes and far inferior health outcomes in those affected.

Yet it's not an epidemic that Canadians or governments are taking concerted and coordinated efforts to address. Though the WHO recommends that countries have a national diabetes strategy, our last one fizzled away in 2013 following a scathing report on its underperformance by the Auditor General. Diabetes is just not a top priority in our country. But it must be.

If we continue with the status quo, the direct costs to our health care system will top $5 billion per year within a decade, and indirect costs will triple that. The human suffering involved is incalculable, particularly for the most vulnerable in our society. Today alone, 480 people will receive a diagnosis of diabetes; six people will suffer a lower limb amputation due to diabetes; our health care system will spend $14 million treating Canadians with diabetes, dozens of whom will experience a medical crisis—stroke, heart attack, kidney failure—necessitating a hospital admission today. Many will even die of diabetes complications.

As stark as that reality is, it doesn't have to be our future. Research and international experience show that with coordinated, focused action we can turn the tide, saving valuable health care resources and improving millions of lives.

It's time for urgent change. This is not an epidemic that can be addressed with personal willpower and shame. To blame and stigmatize those living with type 2 diabetes for their disease is not only unhelpful, it's a vast oversimplification. Type 2 diabetes is caused by a complex array of factors, including genetics, lifestyle, and such environmental factors as poverty, food insecurity, and a disease-promoting food and physical environment.

It's also not a problem that can be effectively addressed without concerted, coordinated effort. Provinces and territories each working on diabetes in their own way will not facilitate the economies of scale and rapid knowledge sharing that are the hallmarks of transformative change. Canada has benefited in the past from the creation of focused initiatives, such as the successful Canadian Partnership Against Cancer and the Mental Health Commission of Canada, to develop and implement national strategies. While the federal government alone can't solve a health crisis, it can play a critical leadership role in convening and coordinating provincial, territorial, and municipal partners.

To really turn the tide of diabetes, we need a nationwide approach that helps all Canadians know their risk of diabetes, reduces individual risk factors, promotes healthier environments, and creates measurable, attainable health outcomes.

In 2018, Diabetes Canada is spearheading just such an approach. To tell you more about this, I turn to Kimberley Hanson, who is leading this initiative.

Ms. Kimberley Hanson (Director, Federal Affairs, Government Relations and Public Policy, Diabetes Canada): Thank you, Jan. It's a pleasure to be here.

As Jan mentioned, in 2018 Diabetes Canada is building on a successful model that has been credited for a transformational breakthrough in the treatment and management of HIV/AIDS, and adapting it to tackle diabetes in Canada. Implementing this approach would mean that, in time, 100% of Canadians would live in an environment that does not promote the development of diabetes; 90% of Canadians would know whether they are at risk of or living with diabetes; 90% of those with pre-diabetes or diabetes would be engaged in interventions that would help them avoid developing diabetes or its complications, and in consequence, 90% would be experiencing improved health outcomes.

This could translate into preventing diabetes in millions of Canadians who are currently on track to develop it. Millions of Canadians with diabetes who are at risk of serious complications like blindness, kidney failure, or amputation would see that risk reduced, and significant time and money would be saved or used more efficiently by our health care system.

Proven prevention programs, if implemented across the country, could save our health care system $1.24 billion over 10 years alone. Greater savings can be realized by helping those with diabetes avoid its complications through more effective management. The savings in human costs are immeasurable.

To develop the best approach possible to tackling the diabetes problem, Diabetes Canada is working with more than 120 expert stakeholders, a number of whom are here today, from nearly 100 organizations in health care, government, the private sector, and education, to recommend how Canada can develop and implement a new approach that will bring real results.

We can't do it alone, however. We need the federal government to partner with us on this initiative. Our teams are working hard to bring forward a recommendation to our government's pre-budget consultation process this summer, but by way of preview, it will include important initiatives such as the following:

Health inequities and food insecurity will be tackled. Regular physical activity will be facilitated for all Canadians. Screening for the risk of diabetes and for its complications will be done more consistently according to best practice. Stigma about diabetes and its causes will be minimized. The health care delivery system will be adjusted to ensure that each patient gets the most appropriate health care provider for their situation and that health care resources are used most efficiently. The rate of complications of diabetes will be reduced, and the sense of overall well-being of people living with diabetes will be improved.

● (1620)

The Chair: Ms. Hanson, I'm going to have to ask you to stop there. We're over time. I want to hear from everybody. We have your notes, but we have to move on to the Juvenile Diabetes Foundation now, for five minutes.

Mr. Dave Prowten (President and Chief Executive Officer, Juvenile Diabetes Research Foundation Canada): Thank you, Mr. Chair and members of the committee.

My name is Dave Prowten. I am the president and CEO of JDRF Canada. I am joined today by Patrick Tohill.

I'd like to begin by thanking you for undertaking this important study. We're especially grateful to Ms. Sidhu for bringing this issue forward.

JDRF Canada is the world's leading charity focused on research to cure, prevent, and treat type 1 diabetes, a potentially fatal autoimmune disease in which a person's pancreas stops producing insulin, making them dependent on daily injections or infusions of insulin for life.

We say type 1 diabetes, or T1D, to distinguish from type 2, a disease in which the body continues to produce insulin but can no longer use it properly. T1D used to be known as juvenile diabetes, but today 85% of those living with type 1 are adults, and 20% are actually diagnosed as adults.

T1D impacts your life 24 hours a day, seven days a week, 365 days a year. It truly is a relentless disease. Food intake, physical activity, and insulin must be carefully balanced to maintain blood glucose levels within a target range. Failure to do so can result in costly and devastating complications.

As I'm sure you know, Canada has a rich legacy of innovation in type 1 diabetes research, from the world-changing discovery of insulin by Banting and Best to the Edmonton protocol for islet transplantation. JDRF is proud to have recently partnered with the Government of Canada to advance this research through the $30-million JDRF-CIHR partnership to defeat diabetes. We'd like to extend a hearty thanks for this support.

Looking to type 1 anti-diabetes strategies abroad, we note that the United States contributes $150 million U.S. annually to type 1 diabetes research. Australia has contributed $35 million over the past five years, and very recently, in the last month, made a nine-year $125-million commitment.

This is a very expensive disease for families and patients. Australia provides support towards the cost of managing the disease by reimbursing the costs of needles, test strips, and consumables. Continuous glucose monitors are provided to children under 21 and insulin pumps to children in low-income families.

Israel also provides reimbursement for diabetes devices, and provides free insulin as well.

In Canada, only Ontario, Alberta, and the three territories provide insulin pumps to people of all ages. In all other provinces these programs end at age 18, 19, or 25. Frankly, we have very poor coverage of continuous glucose monitors, and this technology has proven to be beneficial to Canadians to make their care better and easier.

At the federal level, we'd like to propose five recommendations today, which we hope you will consider in your report.

The first is that the government work with diabetes organizations and other stakeholders, as my colleagues from Diabetes Canada articulated, to develop a national diabetes strategy.

The second is that we create a national diabetes registry of all patients with type 1 diabetes. Registries such as those found in Australia, Scotland, Sweden, and the U.S. are improving our understanding of the epidemiology of diabetes and the effectiveness and value of interventions, which ultimately improve patient outcomes and reduce our health care costs.

Our third request is to permanently fix those issues that led to Canadians with type 1 diabetes being denied access to the disability tax credit and registered disability savings plan. Since December, when the Minister of National Revenue announced that diabetes claims would be reassessed, we've been hearing from grateful supporters whose previously denied claims are now being approved.

JDRF is committed to working with the government and the newly created disability advisory committee. Type 1 diabetics have qualified, since insulin is considered a life-sustaining therapy. We're recommending three key changes going forward. First, it must be recognized that carbohydrate calculation is integral to insulin dosage calculation. Second, the number of hours per week should be reduced from 14 to 10. Finally, RDSPs of those who have at one time qualified for the DTC should be protected so that they can't be clawed back if one's DTC status changes.

A fourth recommendation relates to the government's recently announced plan to study the creation of a national pharmacare program. It would be a missed opportunity, on the eve of the 100th anniversary of the discovery of insulin in Canada, if the various types of insulin were not included among drugs covered under pharmacare.

Our final and most important recommendation is to encourage the government to make significant investments in cure and prevention research. We're getting closer to the time of understanding how this autoimmune disease works. Stopping the immune attack on a body's insulin-producing cells and restoring the ability to produce insulin are of the utmost importance to eradicating type 1 diabetes. Imagine a future in which a Canadian developed a vaccine so that no one would ever get type 1 diabetes again. It is possible.

In closing, I'd like to thank the committee for this opportunity. We look forward to any questions you may have.

● (1625)

The Chair: That was four minutes and 57 seconds.

Voices: Oh, oh!

Mr. Dave Prowten: Can I use the next three seconds?

The Chair: They're gone.

Now we go to Ordre des infirmières et infirmiers du Québec.

[*Translation*]

Ms. Lucie Tremblay (President, Ordre des infirmières et infirmiers du Québec): I would like to thank you for giving us the opportunity to talk to you today. We really appreciate this invitation from the Standing Committee on Health.

Diabetes is clearly an invisible scourge that, like my colleagues said, affects many human lives.

All Canadians should have access to quality, safe care, regardless of where they live. We, nurses, play a very important role with those patients throughout their lives. Whether it is in terms of promotion, prevention or follow-up with clients, we have a close relationship with those types of patients. We will go as far as to adjust treatment or provide customized education, depending on each patient's specific needs.

Quebec nurses have 17 reserved activities, and their scope of practice is among the broadest in Canada. Yet since 2018, in Quebec, community care, including care for individuals living with diabetes in the community, is being taught only at the university level. However, contrary to what is happening in the other Canadian provinces, the Ordre des infirmières et infirmiers issues licenses to both college applicants and university applicants. But one portion of the scope of practice that focuses on treating people with diabetes is not taught during initial training.

As my colleagues have said, the number of diabetes cases is on the rise. People stay in their community, where nurses must intervene to meet the needs of that vulnerable population.

It is absolutely essential for nurses to receive training that covers all the care related to that disease. You will understand that this is a major concern for us. That is why we are appealing to you today. We would like you to, in your considerations or your action plan, make a recommendation on the need to require initial training that covers all the needs of the population, including the needs of the diabetic population.

I will not repeat all the statistics my colleagues have put forward. We know that, when we can intervene quickly, our results are more beneficial. Right now, in my province, 830,000 people are living with diabetes, and 250,000 of them are unaware of it. We need to use the talent of each health care stakeholder to be able to quickly identify health problems.

Nurses play an important role. In the recommendations that will be put forward, you should ensure to use this entire field of practice in order to serve the population better. When that is done, the mortality and morbidity rates decrease. When a patient must undergo an amputation, that is a failure in terms of the care we have provided in the community. So quick intervention is needed to avoid complications, since they have consequences not only for the individual—which always awakens the nurse in me—but also on society as a whole, since those people cannot contribute as much as they would if we were able to keep them in better health.

There are significant gaps in the care provided to diabetics. Among other things, a number of people do not receive the required education on the disease. Once again, nurses can play an important role if they are given an opportunity to do so. By doing that, a certain number of risks are reduced. I think your committee had put forward the fact that 49% of people living with diabetes had not had a foot exam. Yet we know that, if we could intervene quickly, we could save members and human lives. The more knowledge we have and the more we are able to intervene quickly, the more we can prevent complications.

I would now like to quickly propose recommendations. I will try to be as efficient as my colleague and keep my presentation under five minutes.

Of course, what we want to put forward is the importance of prevention, the importance of promoting healthy life habits, the importance of education on diabetes and self-management, as well as the importance of keeping people in their communities.

All that requires us to use the entire scope of practice of nurses. To achieve that, a major strategy must be put forward and advanced practice nurses must be used. For example, I am thinking of specialized nurse practitioners. Expert nurses, nurses who work in the community, should also be used.

● (1630)

In Quebec, we think it is essential for all nurses to receive training on handling patients who need care in their community, especially those with diabetes. Ongoing training must be provided to ensure that patients receive the best possible care throughout their lives.

Thank you for your attention.

[*English*]

The Chair: You're 20 seconds over, but we appreciate the passion.

Ms. Lucie Tremblay:

It takes more time in French.

The Chair: The bells are ringing, and I need unanimous consent to continue on to hear at least two more organizations, which will take 10 minutes.

Do I have unanimous consent for that?

Some hon. members: Agreed.

The Chair: Okay. I'm going to hold us to five minutes, though. The bells are ringing, and we have to go and vote. If the committee decides to come back, we can come back after that, but it's up to the committee to decide. We'll do that in a second.

Dr. Whiteside of Diabetes Action Canada, please proceed.

Dr. Catharine Whiteside (Executive Director, Diabetes Action Canada): Thanks to the committee, and also thanks to Ms. Sidhu.

Diabetes Action Canada is a strategic, patient-oriented research network in chronic disease funded by CIHR and both public and private sector sponsors, including Diabetes Canada and JDRF.

Our mission is to develop patient- and research-informed innovations in equitable health systems, and policy designed to prevent diabetes and its complications.

Today I'm going to share some evidence with you. You've heard a lot of important information already, so I'm going to skip to the bottom line. Diabetes is the leading cause of blindness in working-age Canadians, the leading cause of disabling lower-limb amputation, the leading cause of kidney failure, and the highest risk for heart attacks and stroke. This is a devastating disease that requires lifelong self-management and access to the right care at the right time.

Diabetes more commonly affects vulnerable populations based on determinants of health. Some of these determinants are not modifiable. They are ethnic in origin or age-related. You've heard that there is a high risk in persons of Asian, South Asian, and African descent. Our indigenous people suffer three to five times the rate of diabetes compared to non-indigenous Canadians, and their risk of complications is even higher.

Many determinants, however, are modifiable, such as social and environmental conditions, particularly for indigenous peoples. Canadians in low-income brackets experience four times the risk of diabetes compared to those in high-income brackets. Working Canadians in lower-income brackets without drug benefits must choose between paying for rent and food, and purchasing medications necessary to treat their diabetes and other risk factors. Seniors with diabetes usually suffer many other chronic conditions. They are much more likely to be hospitalized in acute care and long-term care facilities that could be avoided with improved community-based treatment for their complex needs.

We know these facts. Why can't we address the vulnerabilities and prioritize health promotion and prevention of diabetes in Canada? The answer is not easy because to design and implement successful strategies we must activate those social and environmental determinants that support healthy lifestyles and overcome inequities. Access to affordable and healthy foods, and community support for improving physical activity will not be achieved through the health care system. These are major changes that require multiple levels of government, education, social service, and private sectors all working together for collective impact in preventing diabetes.

In addition, immediate changes to our health care system are urgently required to improve outcomes over the next decade. These changes must address the needs of persons living today with diabetes.

In 2015, our researchers conducted a national survey of persons with diabetes from the general population. They identified the fear of blindness, amputation, kidney failure, and, for those on insulin, the fear of low blood sugar that can actually cause death.

Now that Diabetes Action Canada has close ties with indigenous patient partners, we know that they are deeply concerned about the rising rates of diabetes among their youth. All have stated that they do not have access to the right care at the right time. They expect better communication with health-professional teams who understand their needs. They expect better support from community and government resources to improve their self-management of diabetes.

Across the globe, the best diabetes outcomes are reported by countries with digital health tracking systems instituted at regional levels. In Sweden, a national diabetes register tracks the personal health information of the entire diabetes population. The result is that Sweden has achieved some of the best diabetes outcomes in the world at a much lower cost than expended per capita in Canada. Therefore, a national diabetes strategy must include standardized, data-driven performance management of diabetes to track patient outcomes in communities. This will enable continual quality improvement based on best evidence.

● (1635)

In summary, Canada is long overdue for an effective national diabetes strategy that will guide the implementation necessary for effective health system and policy change. Diabetes Action Canada is poised to engage with all of our colleagues and yourselves in the development of this strategy.

Thank you.

The Chair: Thank you very much.

Now we go to the Canadian Indigenous Nurses Association.

Ms. Marilee Nowgesic (Executive Director, Canadian Indigenous Nurses Association): Thank you very much. I am Marilee Nowgesic, the executive director of the Canadian Indigenous Nurses Association. I'm joined by my colleague Isabelle Wallace, who is also one of the registered nurses across the country whom we rely on for their expertise.

At this time, I want to recognize the unceded land of the Algonquin territory on which we meet. I want to pay my respect to the traditional custodians across the lands in which we work, and especially to my ancestors and elders who have guided my journey here today. I want to acknowledge the other knowledge keepers in this room who have prepared comments based on their expertise and experience.

I'm going to skip over a lot of my notes just to make this shorter. There is one typo: while I'd like to say I have 97,000 indigenous nurses across this country, I have to remove one of those zeros: I only have 9,700.

In 2018 we have extended the authentic partnerships developed with external stakeholders who have a shared vision. We continue to work alongside our national indigenous leadership, such as the AFN, ITK, and others such as the First Nations Health Managers Association and the Canadian Association of Schools of Nursing. Each of these partners has made a commitment to advance indigenous nursing.

Lifestyle over the past 50 years has had a great deal of impact, and serious impact, on the health of indigenous people. Our elders have expressed their sadness, because diabetes is killing our people. This is what it is, a killer.

We have seen an ongoing opportunity for this government to support the request to work with your respective caucuses to call on the government to provide funding to explore the establishment and administration of diabetes strategies for indigenous people, using indigenous knowledge-based healing models such as the Four Directions. This would include terms for renewable funding and evaluation for success that is mutually agreed upon by the federal government and national indigenous health professional associations.

As is most times the case, indigenous nurses are the primary care providers at the community level. It is and will be through their diligent efforts that fundamental changes in the design, development, and implementation of health services that will be more responsive to community needs become the reality. These are the health care providers who will utilize whatever tools they have available to adjust food security, manage medication, and give people in these communities the information necessary to make informed decisions about their illness.

Investment in diabetes strategies through regional and national indigenous-based organizations will begin to connect the health gaps between indigenous and non-indigenous groups. Although there are currently several promising practices, they tend to be operated as one-offs. It is necessary to scale up, so that the benefits of these programs can be shared with more communities.

Indigenous knowledge and healing practices must be incorporated into the service delivery framework and the management of such chronic diseases as diabetes, recovery from stroke, and end of life care. Support for programs that will address all aspects of the continuum of care and the overall health status of indigenous people will require partnerships with other health stakeholders, such as the new working relationship that CINA has with Diabetes Canada to develop the diabetes 360 strategy..

We also want to note that communities and health care organizations alike recognize a discrepancy in funding in relation to coverage, standard practices, and requirements for care.

Examples of this discrepancy include the non-insured health benefits program, which is a national program, but one that is too rigid and inconsistent across Canada.

This situation is further complicated by the rising costs of prescription medications. In a recent report released by the Canadian Federation of Nurses Unions called "Body Count: The human cost of financial barriers to prescription medications", 57% of Canadians with diabetes reported failing to adhere to their prescribed therapies because of affordability issues related to medications, devices, and supplies. This is a phenomenon otherwise known as cost-related non-adherence.

The establishment of indigenous health centres in urban centres would improve access to quality health care in a culturally based setting. These centres could provide provincial health facilities with the training and resources to improve delivery in a culturally competent and safe manner.

We see value in focusing on this issue and we call on this government to encourage Indigenous Services Canada, in collaboration with provincial governments, to establish indigenous health centres in urban areas where there are high indigenous populations.

I would now like to turn to Isabelle Wallace.

● (1640)

Ms. Isabelle Wallace (Indigenous Nursing Advisor, Canadian Indigenous Nurses Association): Finally and in brief, CINA has worked on developing programs and policies that will aid in the retention and recruitment of indigenous nurses. We have developed a collaborative mentorship framework to support indigenous nursing students, and we are working with the Canadian Association of Schools of Nursing to implement a supportive mentoring program in nursing schools across Canada.

Diabetes prevention will take on a new perspective once indigenous knowledge is mobilized. Our nursing resources and training in cultural safety for nurses new to working in the north are being reviewed and modified with the changing environments that we find ourselves in. However, this is not sufficient. These initiatives are just a beginning to closing the gaps and addressing the barriers and challenges related to the recruitment and retention of indigenous health care providers.

CINA continues to advocate for the federal government to allocate increased funding for training and development, specifically for indigenous nurses who are at the front line of health care in these communities. We envision that funding would support training, develop community-led opportunities, provide ongoing professional development, and promote cultural safety among all health care professionals.

Ms. Marilee Nowgesic: I'll close there. You have the document.

Thank you for your time. We look forward to your questions.

The Chair: I am so sorry. The bells are ringing. We have 17 minutes to get to the House, to get to our seats to vote. We're not going to have a chance to ask questions, and it's such a shame because you all have so much knowledge. You're all knowledge-keepers, and you have the passion. I'm so sorry this happened.

We're going to have to end the meeting now with your opening statements. We have them. We appreciate them, and you put a lot of work into them.

On behalf of the committee, I want to thank you all for doing this. I apologize for this, but it's just the way this place works.

● (1645)

Ms. Marilee Nowgesic: Thank you very much.

The Chair: You've provided us with a lot, and I'm sure every member got the sense of what you're trying to do. It's a very clear, consistent, message.

Thanks very much.

The meeting is adjourned.

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